STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345376	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carrolton of Fayetteville	**2461 Legion Road , Fayetteville, North Carolina, 28306**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 09/08/2025 through 09/12/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1D5BD7-H1.	E0000		10/03/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/08/2025 through 09/12/2025. Event ID#1D5BD7-H1. The following intakes were investigated: 2607638, 2586437, 2613927, 780678, 780893, 781033, 781031, 781028, 781026, 781004, 781001, 781000, 780998, 780994, 780990, 780992, 780985, and 780981. 37 of the 37 complaint allegations did not result in deficiency.	F0000		10/03/2025
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.	F0552	Immediate action(s) taken for the resident(s) found to have been affected include: Informed consent for psychotropic medication was obtained for resident #55 on September 11, 2025, during the state survey. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents receiving psychotropic medications have the potential to be affected. An audit of all current residents receiving psychotropic medications was conducted by the consulting pharmacist on September 15, 2025, to look for informed consent. The results of this audit were reviewed with Carrolton Facility Management on September 16, 2025, and with the Director of Nursing on September 17, 2025. Informed Consent was obtained for all residents found to be out of compliance from September 17, 2025, to September 30, 2025.	10/03/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0552 SS = D	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to obtain and document consent from a resident's Responsible Party (RP) for the use of psychotropic medications for 1 of 5 residents reviewed for unnecessary medications (Resident #55). The findings included: Resident #55 was admitted to the facility on 8/6/25 with diagnoses that included dementia with behavioral disturbance, depression and cerebral infarction (stroke). A physician order dated 8/6/25 indicated mirtazapine (antidepressant) tablet 15 milligram (mg). Give 0.5 tablet by mouth at bedtime for depression. A physician order dated 8/6/25 indicated quetiapine fumarate (antipsychotic) tablet 25 mg. Give 1 tablet by mouth at bedtime for dementia with behavior disturbances. An admission Minimum Data Set (MDS) assessment dated 8/13/25 coded Resident #55 as severely cognitively impaired. She was coded for having received an antidepressant and antipsychotic in the last 7 days or since admission or reentry if less than 7 days. A review of Resident #55's medical records on 9/9/25 revealed no documentation of consent, a discussion of risk verses benefits, or alternate treatment options with Resident #55's RP for use of psychotropic medications. During an interview with the facility Director of Nursing (DON) on 9/10/25 at 2:00 PM, she indicated that Resident #55 was admitted on 8/6/25 with psychotropic medications and consent should have been obtained at that time to continue administering the psychotropic medications, but it was missed. The DON stated that it was the responsibility of the admitting nurse, unit manager and all licensed nurses entering the orders to ensure consent was obtained prior to administering psychotropic medications. An interview was conducted with the Unit Manager (UM) on 9/12/25 at 8:53 AM. The UM explained that she would normally obtain consent for psychotropic medications use from the resident or RP when the resident was admitted, or a new psychotropic medication was ordered and that consent for Resident #55 was probably missed because it was an evening admission.	F0552	Continued from page 1 Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing personnel (RNs, LPNs, and Medication Aides) were in-serviced by the facility's Director of Nursing (DON)/ Facility Nurse Consultant (FNC) from September 18 to September 24, 2025. The in-services included the following information: Carrolton policy 3.6, "Use of Psychotropic Medication," Use of the "Carrolton Psychotropic Medication Consent." The facility's plan of correction to address the Resident's Right to be Informed and Make Treatment Decisions (F552) Any licensed nurses or medication aides who did not receive the training during this time will not be allowed to work until the training is completed. Newly hired licensed nurses and medication aides will receive training on the Use of Psychotropic Medications and the Residents' Right to Make Informed Treatment Decisions by the DON/Facility Nurse Consultant during the orientation process. The DON and/or Unit Manager will review all admission orders to ensure that informed consent is being obtained for any residents admitted or readmitted to the facility with orders for psychotropic medications. The Chief Nursing Officer and Director of Nursing met on September 28, 2025, to review the results of the week one audit. The following changes were made to the corrective action plan: All new admission medication orders will be reviewed by the unit manager, charge nurse, or the Director of Nursing. Psychotropic consent forms will be prepared in advance for the charge nurse or unit manager to obtain informed consent upon admission/ re-admission to the facility.	

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F0552 SS = D	Continued from page 2 During an interview on 9/12/25 at 11:45 AM with the facility Administrator, he stated that consent should have been obtained from the RP prior to administration of psychotropic medications, when Resident #55 was admitted to the facility.	F0552	Continued from page 2 The Director of Nursing will run the orders listing report in the electronic medical record daily (Monday – Friday) for the previous 24 - 48 hours to ensure that all psychotropic informed consents have been obtained for any newly admitted/re-admitted residents or residents with changes in psychotropic medications requiring informed consent. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The Facility Nurse Consultant, or designee, will complete weekly audits for four (4) consecutive weeks on all new admissions and residents with order changes for psychotropic medication to ensure that all needed informed consents have been obtained. The audit will be conducted using the orders listing report in the electronic medical record with the following settings: Antianxiety medications Anticonvulsants Antidepressants Antihistamines Hypnotics/Sedatives/Sleep disorder agents Psychotherapeutic and Neurological agents This audit will commence the week of September 21, 2025, through the week of October 12, 2025. Any negative findings will be immediately addressed. The Director of Nursing, or designee, will complete daily audits (Monday – Friday) for five (5) consecutive weeks on all new admissions and residents with order changes for psychotropic medication to ensure that all needed informed consents have been obtained. The audit will be conducted using the orders listing report in the electronic medical record with the following settings: Antianxiety medications Anticonvulsants	

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F0552 SS = D		F0552	Continued from page 3 Antidepressants Antihistamines Hypnotics/Sedatives/Sleep disorder agents Psychotherapeutic and Neurological agents This audit will commence the week of September 28, 2025, through the week of October 26, 2025. Any negative findings will be immediately addressed. The consultant pharmacist will continue to review residents receiving psychotropics for compliance with regulations, including informed consent during the monthly pharmacy review. Audit records will be reviewed by the Quality Assessment and Performance Improvement (QAPI) Committee until consistent, substantial compliance has been achieved, as determined by the committee. Corrective action completion date: October 3, 2025.	
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F0578	Immediate action(s) taken for the resident(s) found to have been affected include: The social service history and initial assessment for resident #2, which contained documentation of advanced directive education being completed upon admission, were incomplete at the time of the survey. The social service history and initial assessment for resident #2, including documentation of advanced directive education, were completed during the survey on September 9, 2025. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected by this deficient practice. On September 25, 2025, the Chief Nursing Officer conducted an audit of all admissions to the facility in September 2025 to ensure that all residents or their representatives had received education on advance	10/03/2025

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F0578 SS = D	Continued from page 4 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to inform a resident and/or Responsible Party (RP) of their right to accept or refuse medical or surgical treatment or to formulate an advance directive for 1 of 24 residents reviewed for advance directives (Resident #2). The findings included: Resident #2 was admitted to the facility on 4/30/25. The medical record indicated Resident #2's RP was her legal guardian. A physician order for Resident #2 dated 4/30/25 indicated full code status. A social service history and initial assessment form completed by the Social Worker (SW) with an effective date of 5/1/25 included an advanced care planning section that had not been completed. Resident #2's quarterly Minimum Data Set (MDS) assessment dated 8/7/25 coded Resident #2 as moderately cognitively impaired. A review of the medical record revealed no documentation that Resident #2 or her RP was informed of the right to refuse medical or surgical treatment or to formulate an advance directive.	F0578	Continued from page 4 directives. The results of this audit were discussed with facility leaders (including the Administrator, Director of Nursing, Director of Social Work, and Social Work Assistant) on September 25, 2025. There were no residents admitted to the facility in September 2025 who were found to be without evidence of advanced directive education upon admission. Actions taken/systems put into place to reduce the risk of future occurrence include: Social Work Staff (including the Director of Social Work and Social Work Assistant) were in-serviced on the facility's procedures regarding Advance Directives on September 25, 2025, by the Carrolton Facility Management Chief Nursing Officer and the facility Administrator. This in-service covered the following items: Carrolton Policy 2.2 Residents' Rights Regarding Treatment and Advance Directives Carrolton Do Not Resuscitate Consent Form 2.2a Procedures to ensure that advance directives education is completed and documented upon admission to the facility. Procedures to verify advance directives upon re-admission to the facility (including a process change for the social worker to complete a re-assessment of advance directives for all residents re-admitted to the facility using the quarterly assessment tool in the electronic medical record.) The facility's plan of correction for ensuring that Residents' Rights Regarding Treatment and Advance Directives are honored (F 578). Newly hired social work staff will receive training on Advance Directive processes by the Administrator, Director of Social Work, or Facility Nurse Consultant during the orientation process.	

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F0578 SS = D	Continued from page 5 An interview was conducted on 9/12/25 at 8:34 AM with the SW. She indicated she normally discussed advance directives with the resident or resident's RP during admission. She stated that she had been trying to get in touch with Resident #2's RP via telephone to discuss advance directives and that she should have sent a certified letter to the RP informing her to contact the facility after 3 phone call attempts. The SW stated she was able to get in touch with Resident #2's RP on 9/9/25 and discussed the advanced care planning information with RP to include the right to formulate an advance directive and updated Resident #2's medical records to include the information discussed with RP on 9/9/25. During an interview on 9/12/25 at 8:44 AM with the Director of Nursing (DON) she indicated the SW should have followed up with Resident #2's RP to discuss advance directives. During an interview on 9/12/25 at 11:43 AM with the Administrator, he indicated advance directives were normally discussed with resident or RP during admission and that the SW should have followed up and ensured advance directives were discussed and documented in Resident #2's medical records.	F0578	Continued from page 5 Licensed nurses (including LPNs and RNs) were in-serviced on the facility's procedures regarding Advance Directives, September 25 through September 30, 2025, by the Director of Nursing. These in-services covered the following items: Carrolton Policy 2.2 Residents' Rights Regarding Treatment and Advance Directives Carrolton Do Not Resuscitate Consent Form 2.2a Procedures to ensure that advance directive education and code status are completed and documented upon admission to the facility. The facility's plan of correction for ensuring that Residents' Rights Regarding Treatment and Advanced Directives are honored (F 578). Newly hired nursing staff will receive training on Advance Directive processes by the Director of Nursing, Director of Social Work, or Facility Nurse Consultant during the orientation process. How the corrective action(s) will be monitored to ensure the practice will not recur: The Facility Nurse Consultant or Chief Nursing Officer will complete weekly audits for four (4) weeks of all admissions to ensure that advanced directive education has been provided. Audits will begin the week of September 29, 2025, and continue through the week of October 20, 2025. Audit records will be reviewed by the Quality Assurance/Performance Improvement (QAPI) Committee until consistent, substantial compliance has been achieved, as determined by the committee. Corrective action completion date: October 3, 2025.	
F0628 SS = A	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii)	F0628		10/03/2025

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F0628 SS = A	Continued from page 6 §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F0628		

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F0628 SS = A	Continued from page 7 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F0628		

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F0628 SS = A	Continued from page 8 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F0628		

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F0628 SS = A	Continued from page 9 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff interview, the facility failed to notify the resident representative (RR) in writing of the reason for the transfer to the hospital and had not mailed a copy of the bed hold policy for 1 of 1 resident reviewed for hospitalization (Resident #122). The findings included: Resident #122 was admitted to the facility on 07/01/2025 and was discharged on 07/08/2025 and did not return.	F0628		

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F0628 SS = A	Continued from page 10 The discharge Minimum Data Set (MDS) dated 07/07/2025 was coded Resident #122 as severely cognitively impaired and was discharged with return anticipated. A progress note dated 07/07/2025 revealed the RR was made aware Resident #122 was to be sent to emergency room (ER) per order from the Medical Doctor (MD). A progress note dated 07/07/2025 revealed Resident #122 was noted to have shortness of breath (SOB) and accelerated heart rate (HR). Resident #122 was put on 2 liters of O2. The residents O2 sat was 88%. The MD was notified, and the resident was sent to the ER for further evaluation. A hospital transfer note dated 07/07/2025 revealed the RR was notified of transfer and was also made aware of Resident #122s clinical situation. There was no documentation that a written notice of transfer to the hospital was provided, or a notice of the bed hold policy mailed. An interview was conducted with the Director of Nursing (DON) on 09/12/2025 at 12:37 PM. The DON stated they were documenting bed holds and the reason for transfers but had not given the RR of Resident #122 the reason for the transfer to the hospital or the bed hold policy in writing. The DON also stated that going forward she expects a letter to be compiled to notify family and/or residents of the reason for transfer and will include the bed hold policy.	F0628		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all	F0644	Immediate action(s) taken for the resident(s) found to have been affected include: The Social Work Director submitted a North Carolina Medicaid Uniform Screening Tool (NCMUST) for Resident #10 on September 24, 2025, for additional screening. An onsite visit was conducted at the facility on September 26, 2025, to assess the resident for pre-admission screening and resident review (PASRR) level determination. On September 30, 2025, the facility was notified that resident #10 did not meet the criteria for mental illness and would require no further screening. Identification of other residents having the potential to be affected was accomplished by:	10/03/2025

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F0644 SS = D	Continued from page 11 residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to complete a Preadmission Screening and Resident Review (PASRR) application for a resident with newly evident mental health diagnoses for 1 of 2 sampled resident reviewed for PASRR (Resident #10). The findings included: Resident #10 was readmitted to the facility on 12/19/2024 with diagnoses including unspecified psychosis not due to a substance or known physiological condition and psychotic disorder with hallucinations due to known physiological condition. The admission Minimum Data Set (MDS) dated 12/26/2024 had Resident #10 coded as severely cognitively impaired and was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Resident #10 had listed diagnosis of psychotic disorder (other than schizophrenia) and vascular dementia, unspecified severity, with mood disturbance. An interview with the Social Worker (SW) was conducted on 09/10/2025 at 9:40 AM. The SW stated she was not an employee in 2024 and was currently responsible for completing PASRR screenings for residents. The SW also stated a PASSR level II screening should have been completed and submitted for Resident #10 when she was readmitted to the facility on 12/19/2024 with new mental health diagnoses of unspecified psychosis not due to a substance or known physiological condition and psychotic disorder with hallucinations due to known physiological condition. An interview with the Director of Nursing (DON) was conducted on 09/12/2025 at 10:28 AM. The DON indicated the SW was expected to complete a PASRR level II screening for all residents with a mental health diagnosis.	F0644	Continued from page 11 The facility has determined that all residents have the potential to be affected by this deficient practice. Carrollton Central Intake staff completed a review of residents in the facility on September 24, 2025, to ensure that individuals with mental disorders, intellectual disabilities, or related conditions have been screened appropriately. The results of this audit were discussed with facility leaders (including the Administrator, Director of Nursing, Director of Social Work, and Social Work Assistant) on September 25, 2025. The Social Work Director submitted North Carolina Medicaid Uniform Screening Tools (NCMUST) for residents identified in the audit as needing additional screening from September 26 to 30, 2025. Actions taken/systems put into place to reduce the risk of future occurrence include: Social Work Staff (including the Director of Social Work and Social Work Assistant) were in-serviced on the facility's procedures regarding pre-admission screening and resident review (PASRR) to ensure that individuals with a mental disorder, intellectual disability, or a related condition receive care and services in the most integrated setting appropriate to their needs on September 25, 2025, by the Carrolton Facility Management Chief Nursing Officer. This in-service covered the following items: Carrolton Policy 5.7 Resident Assessment – Coordination with PASARR Program Procedures to keep track of each resident's PASARR screening status and referring to the appropriate authority for additional screening as needed. The facility's plan of correction for Resident Assessment – Coordination of PASARR and Assessments (F644) Newly hired social work staff will receive training on PASARR processes by the Administrator, Director of Social Work, or Facility Nurse Consultant during the	

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F0644 SS = D		F0644	Continued from page 12 orientation process. How the corrective action(s) will be monitored to ensure the practice will not recur: Carrolton Central Intake staff will complete weekly audits for four (4) weeks of all admissions to ensure that individuals with mental disorders, intellectual disabilities, or related conditions have been screened appropriately. Audits will begin the week of September 29, 2025, and continue through the week of October 20, 2025. Audit records will be reviewed by the Quality Assurance/Performance Improvement (QAPI) Committee until consistent, substantial compliance has been achieved, as determined by the committee. Corrective action completion date: October 3, 2025.	
F0814 SS = F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interviews, the facility failed to ensure debris was removed from in front of the dumpsters for 2 of 3 dumpsters observed. The facility also failed to ensure that the doors to the dumpsters were closed for 1 of 3 dumpsters. This practice had the potential to attract pests and rodents. The findings included: An observation of the dumpster area and interview with the Dietary Manager was conducted on 9/8/25 at 7:22 AM. Three dumpsters were observed lined up in a row. The middle dumpster door was open on the right side and debris was in front of the middle dumpster and right dumpster. The debris included used gloves, used napkins, and a large pile of lint from a washing machine. The Dietary Manager stated that his department was responsible for the dumpster area, but all departments used the dumpsters. He further stated that his staff were supposed to clean up the dumpster area daily.	F0814	Immediate action(s) taken for the resident(s) found to have been affected include: On September 8, 2025, garbage was identified on the grounds surrounding the garbage dumpsters. The garbage was immediately cleaned up on September 8, 2025, by the housekeeping staff. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected by this deficient practice. Actions taken/systems put into place to reduce the risk of future occurrence include: On September 22, 2025, the facility Administrator developed and implemented a monitoring tool to ensure the proper disposal of garbage and refuse in dumpsters. The dumpster area will be monitored daily, and any need to clean the area will be documented. Carrollton Facility Management (CFM) implemented	10/03/2025

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F0814 SS = F	Continued from page 13 The Administrator was interviewed on 9/12/25 at 9:34 AM. He revealed that trash was picked up three days each week and often, debris would be left on the ground afterward and the doors would slide open. There was a reacher available near the dumpsters, so anyone could pick up the loose items or close the dumpster doors as well. The Administrator stated that there was not a cleaning schedule for the dumpster area, but rather staff were expected to pick up any items if seen.	F0814	Continued from page 13 Carrolton Policy 15.2, Disposal of Garbage and Refuse, on September 24, 2025. On September 24, 2025, the facility Administrator in-serviced all housekeeping, dietary, and maintenance staff on the following items: Ensuring the dumpster area is kept clean. The new process for monitoring the dumpster area. The plan of correction for the Disposal of Garbage and Refuse (F814). How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrator, Maintenance Director, or their designee will monitor the dumpster cleaning logs daily for four (4) weeks. The Administrator, Maintenance Director, or their designee will conduct random site visits to the dumpster area at least five (5) times a week for two (2) weeks, then at least three (3) times a week for two (2) weeks to ensure the area remains clean. This monitoring will occur for four (4) consecutive weeks beginning the week of September 22 through the week of October 13, 2025. The monitoring tools will serve as our audits and will be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meeting until consistent, substantial compliance has been achieved, as determined by the QAPI committee. Corrective action completion date: October 3, 2025	